

**CLAIM FORM-DRUG/PHARMACY**

ND DEPARTMENT OF HUMAN SERVICES/MEDICAL SERVICES

SFN 634 (Rev. 05-2003)

**THIS FORM MUST BE TYPED-TYPE IN WHITE AREAS ONLY. SEE BACK OF FORM FOR INSTRUCTIONS.**(1) **FOR STATE USE ONLY**

(2) Recipient I.D. Number:				(3) Provider Number:		(4) Provider Name:				
Patient Name: (Last, First, Middle)				Provider Phone Number:		Address 1:				
Date of Birth:				Address 2:						
(5) Authorization Number:				Address 3:						
<b>(6) CHECK BOX APPLICABLE FOR RECIPIENT RESIDENCE ON DATE OF SERVICE (ONE ONLY)</b>										
<input type="checkbox"/> A. SNF <input type="checkbox"/> B. ICF <input type="checkbox"/> C. ICF/MR <input type="checkbox"/> D. Swing Bed <input type="checkbox"/> E. Custodial Care <input type="checkbox"/> F. Private Residence <input type="checkbox"/> G. Other										
<b>0</b>	(7) Date of Service:	(8) RX Number:	(9) Original RX Date:	(10) Metric Quantity:	(11) Days Supp.:	(12) Refill:	(13) Dr. Number:	(14) MD Cert:	(15) Charge:	
	(16) Drug Name:		(17) NDC Number:		(18) Conc.:		(19) MFG:			
<b>1</b>	(7) Date of Service:	(8) RX Number:	(9) Original RX Date:	(10) Metric Quantity:	(11) Days Supp.:	(12) Refill:	(13) Dr. Number:	(14) MD Cert:	(15) Charge:	
	(16) Drug Name:		(17) NDC Number:		(18) Conc.:		(19) MFG:			
<b>2</b>	(7) Date of Service:	(8) RX Number:	(9) Original RX Date:	(10) Metric Quantity:	(11) Days Supp.:	(12) Refill:	(13) Dr. Number:	(14) MD Cert:	(15) Charge:	
	(16) Drug Name:		(17) NDC Number:		(18) Conc.:		(19) MFG:			
<b>3</b>	(7) Date of Service:	(8) RX Number:	(9) Original RX Date:	(10) Metric Quantity:	(11) Days Supp.:	(12) Refill:	(13) Dr. Number:	(14) MD Cert:	(15) Charge:	
	(16) Drug Name:		(17) NDC Number:		(18) Conc.:		(19) MFG:			
<b>4</b>	(7) Date of Service:	(8) RX Number:	(9) Original RX Date:	(10) Metric Quantity:	(11) Days Supp.:	(12) Refill:	(13) Dr. Number:	(14) MD Cert:	(15) Charge:	
	(16) Drug Name:		(17) NDC Number:		(18) Conc.:		(19) MFG:			
<b>5</b>	(7) Date of Service:	(8) RX Number:	(9) Original RX Date:	(10) Metric Quantity:	(11) Days Supp.:	(12) Refill:	(13) Dr. Number:	(14) MD Cert:	(15) Charge:	
	(16) Drug Name:		(17) NDC Number:		(18) Conc.:		(19) MFG:			
<b>6</b>	(7) Date of Service:	(8) RX Number:	(9) Original RX Date:	(10) Metric Quantity:	(11) Days Supp.:	(12) Refill:	(13) Dr. Number:	(14) MD Cert:	(15) Charge:	
	(16) Drug Name:		(17) NDC Number:		(18) Conc.:		(19) MFG:			
(20) Remarks:			<b>(21) CERTIFICATE AND AGREEMENT OF PROVIDER:</b> THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND ACCEPT AS PAYMENT IN FULL, THE AMOUNTS PAID, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. That the services herein charged were actually rendered and were rendered under the conditions specified, and that no part of such bill, claim account or demand has been paid. That the services provided and billed for qualify for federal participation under 42USC 1396(a) et.seq. and the rules and regulations promulgated, and adopted, thereunder. I further certify that the goods and services hereby designated are furnished without discrimination as to age, sex, race, color, national origin, religion, political affiliation or handicap. I agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State Plan and to furnish the State Agency with such information regarding any payments claimed by such person or institution for providing services under the State Plan, as the State Agency may from time to time request.				(22) TOTAL CHARGES			
							(23) LESS: OTHER INS. PAYMENT AND/OR DISCOUNT			
							(24) BALANCE DUE			
							(25) MAIL TO:			
							Medical Services ND Department of Human Services 600 E Boulevard Ave - Dept 325 Bismarck ND 58505			
			By Registered Pharmacist (for the provider):		Date:					

## IMPORTANT INSTRUCTIONS

Please help us help you! By carefully following these instructions we can process this form quickly and accurately.

### CAREFULLY TYPE THIS FORM:

- It must be typewritten
- Type only in WHITE AREAS shown, DO NOT type in shaded areas.
- Use all capital letters
- Do not use italics or script
- All monetary amounts are entered without decimals, commas or dollar signs
- All dates are six digits, without hyphens, dashes, slashes, or spaces (MMDDYY)
- Use a black ribbon only
- Use a clean typewriter
- Avoid mistakes, if you do make a mistake, carefully correct it with lift off tape (preferred). If you must use white out, cover the correction with a small piece of transparent tape to protect it. DO NOT ERASE.
- Return the original to the address shown on front.

### Thank You!

1. BLOCK (1) FOR STATE USE ONLY - DO NOT WRITE, TYPE OR STAPLE IN THIS SPACE.
2. BLOCK (2) RECIPIENT I.D. NO. - ENTRY REQUIRED. ENTER TYPEWRITTEN 9-DIGIT RECIPIENT IDENTIFICATION NUMBER SHOWN ON ELIGIBILITY STATUS NOTICE PROVIDED RECIPIENT BY MEDICAL SERVICES. ENTRY REQUIRED FOR PATIENT NAME AS IT APPEARS ON SAME NOTICE AND DATE OF BIRTH IN 6-DIGIT MONTH, DAY AND YEAR FORMAT (MMDDYY).
3. BLOCK (3) PROVIDER NO. - ENTRY REQUIRED. ENTER TYPEWRITTEN PROVIDER NUMBER ASSIGNED BY NORTH DAKOTA MEDICAID PROGRAM.
4. BLOCK (4) PROVIDER NAME - ENTRY REQUIRED. ENTER TYPEWRITTEN 5-DIGIT PROVIDER NAME AS IT APPEARS ON PHARMACY AGREEMENT/MEDICAL ASSISTANCE PROGRAM AND PROVIDER ADDRESS.
5. BLOCK (5) AUTHORIZATION NO. - PRE-PRINTED.
6. BLOCK (6) ENTER AN "x" IN BOX APPLICABLE FOR RECIPIENT RESIDENCE ON DATE OF SERVICE (ONE ONLY).
7. BLOCKS (7) DATE OF SERVICE AND (9) ORIGINAL RX DATE - ENTRY REQUIRED FOR EACH PRESCRIPTION. MUST BE A 6-DIGIT ENTRY IN MONTH, DAY AND YEAR FORMAT (MMDDYY): USE NO HYPHENS OR SPACES, I.E., JANUARY 1, 1987 SHOULD BE 010187.
8. BLOCK (8) RX NO. - ENTRY REQUIRED FOR EACH PRESCRIPTION.
9. BLOCK (10) METRIC QTY. - ENTRY REQUIRED. ENTER TOTAL QUANTITY, WEIGHT, OR VOLUME IN METRIC UNITS ONLY. USE NO DECIMALS OR FRACTIONS, ONLY WHOLE NUMBERS, USE NO METRIC DESCRIPTION ABBREVIATIONS, I.E., MG, GM., ETC.
10. BLOCK (11) DAYS SUPP. - ENTRY REQUIRED. ESTIMATES ACCEPTABLE FOR TOPICAL, INHALANT, DURABLE MEDICAL EQUIPMENT, AND PRN PRODUCTS.
11. BLOCK (12) REFILL - ENTRY REQUIRED. ALWAYS ENTER "0" WHEN PRESCRIPTION IS FILLED FOR THE FIRST TIME. REFILLS ALLOWED MUST BE WITHIN ONE YEAR FROM DATE OF ORIGINAL PRESCRIPTION.
12. BLOCK (13) DR. NO. - ENTRY REQUIRED. IF THE PRESCRIBING DOCTOR PROVIDER NUMBER IS NOT AVAILABLE ON THE CURRENT ND MEDICAID PROVIDER LISTING, ENTER THE PRESCRIPTION LINE NUMBER (0 THROUGH 6) AND DOCTOR'S NAME IN BLOCK (21), REMARKS. IN STATE NON LISTED NUMBER IS 52928 AND OUT OF STATE DEFAULT NUMBER IS 53168.
13. BLOCK (14) MD CERT. - ENTER AN "X" IN THIS BLOCK ONLY IF THE DOCTOR HAS HANDWRITTEN THE WORDS "BRAND NECESSARY" ON THE PRESCRIPTION FORM. MAC DRUGS ONLY.
14. BLOCK (15) CHARGE. - ENTRY REQUIRED. USE NO DOLLAR SIGNS OR DECIMALS.
15. BLOCK (16) DRUG NAME - ENTRY REQUIRED. MUST BE THE NAME OF THE DRUG/ITEM DISPENSED AS SHOWN ON THE PRODUCT CONTAINER OR AS COMMONLY KNOWN.
16. BLOCK (17) NDC NO. - ENTRY REQUIRED. MUST BE 11-DIGIT NUMBER WITH A 5-4-2 CONFIGURATION; USE NO HYPHENS OR SPACES. FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES, ENTER THE STATE ASSIGNED DME CODE NUMBER. DO NOT ENTER MANUFACTURER'S LIST NUMBERS, CATALOG NUMBERS OR UPC CODES. FOR COMPOUNDED ITEMS, REFER TO CPD LIST IN PROVIDER MANUAL AND INDICATE INGREDIENTS AND QUANTITIES IN BLOCK (21) REMARKS.
17. BLOCK (18) CONC. - ENTRY REQUIRED. THE CONCENTRATION OR STRENGTH OF A DRUG MUST BE ENTERED; USE STD OR REG FOR COMBINATION PRODUCTS OR SUPPLIES. USE NO METRIC ABBREVIATIONS, I.E., MG, GM., ETC.
18. BLOCK (19) MFG. - ENTER AS SHOWN ON PRODUCT CONTAINER.
19. BLOCK (20) REMARKS - ENTER ANY ADDITIONAL REMARKS PERTINENT TO CLAIMS SUBMITTED.
20. BLOCK (21) CERTIFICATE & AGREEMENT OF PROVIDER - ENTER DATE COMPLETED IN MONTH, DAY AND YEAR FORMAT (MMDDYY), AND FULL SIGNATURE OF REGISTERED PHARMACIST.
21. BLOCKS (22) TOTAL CHARGES, (23) LESS: OTHER INS. PAYMENT AND/OR DISCOUNT & (24) BALANCE DUE - ENTRY REQUIRED BLOCKS (22) AND (24). BALANCE DUE, BLOCK (24) EQUALS TOTAL CHARGES, BLOCK (22) MINUS OTHER INSURANCE PAYMENT AND/OR DISCOUNT, BLOCK (23). USE NO DOLLARS SIGNS OR DECIMALS. CHECK ARITHMETIC.

**DIRECT BILLING QUESTIONS TO MEDICAL SERVICES DIVISION AT (701) 328-4030.**

### DISTRIBUTION:

**Original** - Forward to Medical Services, ND Department of Human Services, 600 E Boulevard Ave Dept. 325, Bismarck ND 58505  
**Pink** - Retained by Provider